

Patient Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

SS#: _____ DOB: _____ Sex: M or F

Dental History:

Last time you saw a dentist: _____

Last full mouth x-rays: _____

Are you having problems now, if so, what? _____

Do you have your teeth cleaned regularly? YES NO

Are you apprehensive about dental treatment? YES NO

Have you had any periodontal (Gum) treatment? YES NO

Do your gums bleed, feel tender, or irritated? YES NO

Are your teeth sensitive to hot, cold, sweets, pressure? YES NO

Are you aware of grinding or clenching your teeth? YES NO

Do you have headaches, earaches or neck pains? YES NO

Have you worn braces on your teeth? (Orthodontics) YES NO

Medical History:

Are you under a physician's care now? YES NO If yes, who? _____

Have you ever been hospitalized or had a major operation? YES NO If yes, what? _____

Have you ever had a serious head or neck injury? YES NO If yes, what? _____

List any medications you are currently taking (Name and Dosage): _____

Have you ever been instructed to take antibiotics before dental work? YES NO

Do you have history of infective endocarditis? YES NO _____

Do you have a prosthetic heart valve or had a heart valve replacement? YES NO _____

Do you have a congenital heart defect? YES NO _____

Have you ever had a heart transplant? YES NO _____

Do you take or have you taken, Phen-Fen or Redux? YES NO

Have you ever taken Fosamax, Boniva, Actonel, Prolia or any other medications containing Bisphosphonates? YES NO If yes, what? _____

Are you on any blood thinners? YES NO If yes, what? _____

Are you currently taking/have taken steroids on a continued basis? YES NO If yes, what and how long? _____

Do you use tobacco? YES NO If yes, how often? _____

Do you drink alcohol? YES NO If yes, how often? _____

(Women) Are you pregnant? YES NO (Women) Do you take oral contraceptives? YES NO

**Miller Family & Cosmetic Dentistry
Dr. Miller, Thomas, and Ta**

PAYMENT POLICY

PAYMENT IS DUE AND EXPECTED AS SERVICES ARE RENDERED- UNLESS A PREVIOUS PAYMENT ARRANGEMENT HAS BEEN MADE WITH OUR BUSINESS ASSISTANTS.

Fees are payable by cash, check, Visa, Mastercard, Discover and American Express. Any questions concerning fees should be discussed with business assistants and patient coordinator.

OFFICE POLICY ON INSURANCE

Our fees are the same for all patients, whether they have a dental insurance program. Your insurance coverage may not include benefits for services rendered in this office. The benefits you may receive are in accordance with terms set down at the time of purchase either by your employer or by yourself. The amount you receive from your insurance company depends on the terms of your contract with that company. No two contracts are alike. Some cover all fees, some cover part of your expenses and some cover none. Regardless of company or contract, there is a relationship between this office and the patient, but there is none with the insurance carrier. Professional services are rendered and charged to the patient, not the insurance company, with the patient responsible for the account.

We file insurance claims for payment as a COURTESY to you, however, you must provide us with your correct insurance information each visit. Insurance assignment as payment or partial payment is accepted only if a written pre-authorization from the insurance company is on file. We will be happy to file a pre-authorization on any treatment recommended. It normally takes 3-6 weeks to receive this information.

If we do accept payment arrangements, please make note that we are very strict on our payment/collection policy. IF after 3 consecutive months without any contact from you regarding your balance due or payment made, we will turn your account over to TEK COLLECT Collection agency.

APPOINTMENTS

Appointments are reservations of valuable time, your and ours. Help us, help you by keeping all scheduled appointments. Please give at least 24 hours' notice (MORE IF POSSIBLE) if you must change your appointment, allowing someone else to utilize that time. **We DO charge for broken appointments or late cancellations. (This is a cancellation with less than 24 hours' notice.) These charges are a minimum of \$25.00.**

I hereby certify that I have read, understand, and agree to the above payment, insurance, collections, and appointment policy statement. I also authorize the release of any information necessary to process my insurance.

SIGNED: _____ DATE: _____

Patient Name (F,M,L): _____

Patient Address: _____

House Phone # _____ Cell Phone # _____ Work # _____

DOB: _____ SSN: _____ Sex: _____ Race: _____ Marital Status: S M D W

Patient Occupation/Student status (Part time/full time): _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Financially Responsible Person for Account: _____

Relationship to patient: _____

Address: _____

Phone #: _____ DOB: _____ SSN: _____

DENTAL INSURANCE:

Primary insurance Policy Holder Name (self/spouse/parent): _____

Policy Holder Employer: _____

Primary Insurance Company Name: _____

Policy Holder Member ID #: _____

Secondary Insurance Policy Holder Name (self/spouse/parent): _____

Policy Holder Employer: _____

Secondary Insurance Company Name: _____

Policy Holder Member ID #: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

For updated guidelines effective August 2015.

Name: _____ Date of Birth: _____

TO THE PATIENT: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the used and disclosures we may make of your protected health information. A copy of our notice accompanies this Consent.

We reserve the right to change our privacy practices as describe in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURES:

I, _____, have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to you use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

EMAILING OF X-RAYS:

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists, this allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission to this service.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

Personal Health Information Disclosure Agreement

I, _____, do hereby grant permission Family & Cosmetic Dentistry, to disclose my personal health information to the following personal representative(s):
(Spouse, Sibling, Parent, Child or Friend)

Name/Phone Number: _____

Name/Phone Number: _____

Name/Phone Number: _____

Name/Phone Number: _____

Information to be disclosed (Please check):

- Appointment dates and times
- Treatment plans and referrals
- Financial and billing information
- Any other pertinent dental health information related to treatment at this office
- None of the above

I understand that this permission will remain in effect unless a written cancellation has been provided to Family & Cosmetic Dentistry.

Patient Signature

Date

Patient Date of Birth

Witness Signature

Date

How would you like us to communicate with you?

Our office sends appointment reminders, information about treatment, payment, insurance and other communications. Please let us know how you would like us to communicate with you.

Your name: _____ Date: _____

Check all that apply (please print clearly):

Contact me by U.S. Mail at the following address: _____

Contact me by Email at the following email address: _____

For Phone and Text Communications

This form is optional. You are not required to sign this form and you do not need to sign it to receive care in our dental office.

Phone Number: _____

By checking this box, I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or pre-recorded voice or telephone equipment that may be capable of automatic dialing. This dentist practice may:

- Call me
- Call and Text me

Signature: _____ Date: _____

Please call us right way if you get a new telephone number!
